MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2006

HMO COLORADO, INC
700 Broadway
Denver, Colorado 80273-0001

NAIC Group Code 0671
NAIC Company Code 95473

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
AND
INDEPENDENT CONTRACTOR EXAMINERS
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

CERTIFICATE OF COPY
Of
REPORT OF EXAMINATION

I, **Marcy Morrison**, Commissioner of Insurance of the State of Colorado, do hereby certify that the attached is a true and correct copy of the duplicate original Report of Market Conduct Examination as of December 31, 2006 now on file for **HMO Colorado, Inc.** as a record of the office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal of office at the City and County of Denver this 18th day of July 2008.

Marcy Morrison
Commissioner of Insurance

HMO COLORADO, INC
700 Broadway
Denver, Colorado 80273-0001

LIMITED MARKET CONDUCT EXAMINATION REPORT

as of
December 31, 2006

Examination Performed by:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Violetta R. Pinkerton, CIE, CPCU, CPIW
John E. Bell

State Market Conduct Examiners

And

Charlotte J. Howell, CIE, MBA
Victor M. Negron, AIE, FLMI

Independent Contract Examiners

March 5, 2008

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of HMO Colorado, Inc. was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S., which authorize the Commissioner of Insurance to examine insurance companies and health maintenance organizations. We examined the Company's records at its office located at 700 Broadway, Denver, Colorado, 80273 and at the Colorado Division of Insurance offices at 1560 Broadway, Suite 850, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2006, through December 31, 2006.

The following market conduct examiners respectfully submit the results of the examination:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, CPCU, CPIW

John E. Bell

Charlotte J. Howell, MBA, CIE

Victor M. Negron, AIE, FLMI

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COMPANY PROFILE

The following profile is based on information provided by the Company:

HMO Colorado, Inc. (HMOC or Company) is a domestic for-profit health maintenance organization (HMO). General Health Corporation, Inc. (GHC) was formed in 1985 to operate as a holding company owning, managing and operating companies which were authorized to do business under Title 10 of the Colorado Revised Statutes. GHC directly owned HMOC until GHC was dissolved on September 10, 1998 on which date HMOC became a wholly owned subsidiary of Rocky Mountain Hospital and Medical Service (RMHMS). On November 16, 1999, RMHMS converted from a non-profit hospital, medical-surgical and health service corporation to a stock property and casualty insurance company and issued its stock to Anthem Insurance Companies, Inc. After the conversion, the name of RMHMS was changed to Rocky Mountain Hospital and Medical Service, Inc. (RMHMS, Inc.). HMOC became a wholly owned subsidiary of RMHMS, Inc., which is a wholly owned subsidiary of Anthem Holding Company, LLC, which in turn, is 100% owned by WellPoint, Inc.

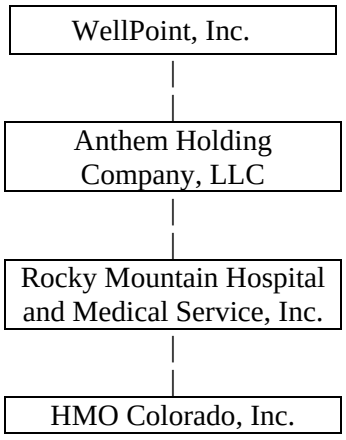
HMOC was federally qualified as a Health Maintenance Organization pursuant to the Public Health Service Act on January 1, 1986.

HMOC received its Certificate of Authority in Colorado on November 8, 1979.

A corporate structure chart as of December 31, 2006 is shown on the next page.

HMOC also operates in the State of Nevada under its Certificate of Authority effective December 7, 1993. HMOC's operational territory includes all counties in Colorado and Nevada. HMOC does business in Nevada under its trade name HMO Nevada.

HMOC's NAIC Company Code is 95473 and its NAIC Group Code is 671.



Service Area

The Company is licensed to provide services in all counties in Colorado.

Enrollment as of December 31, 2006:		54,549
Total Written Premium:		$172,608,000
Small Group Written Premium:		$21,987,162
Market Share	(Colorado HMOs only):	4.64%

Health Care Delivery:

HMOC contracts with independent physician associations, physician group practices, and independent physicians, as well as hospitals, mental health facilities and other ancillary providers to provide primary and specialty care. The Company pays for health care services through a combination of capitation, negotiated fee-for-service and per diem arrangements.

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance (Division), who were assisted by independent contract examiners, reviewed certain business practices of HMO Colorado, Inc. The limited market conduct examination was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S., which empower the Commissioner to examine any entity engaged in the business of insurance The information in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related primarily to HMOs. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or submitted by the Company. The limited market conduct examination covered the period from January 1, 2006, through December 31, 2006.

The examination included review of the following:

Company Operations and Management
Contract Forms
New Business Applications and Renewals
Cancellations/Declinations/Terminations
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain any improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms permit the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance laws as they pertained to HMOs. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the

examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. The examination was conducted concurrently with an examination of Rocky Mountain Hospital and Medical Service, Inc. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although HMOC and Rocky Mountain Hospital and Medical Service, Inc. are separate companies, certain policies, procedures and forms are common to both companies.

Therefore, it was agreed that in those cases where it appeared that a policy, procedure or form may be applicable to both companies, the examiners would "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions - definitions.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests

Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" for Use in Accident and Health Insurance Contracts and Certificates
Insurance Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation Of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-6-2	Group Coordination of Benefits.
Insurance Regulation 4-6-5	Concerning Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-2	Concerning The Laws Regulating Health Maintenance Organizations Benefit Contracts and Services In Colorado
Emergency Insurance Regulation 05-E-5	Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous market conduct examination dated June 28, 2001, which covered the period of January 1, 2000 through December 31, 2000. The Company was also the subject of a financial examination conducted by the Division's financial examiners that was completed in November 2004, and covered the period of January 1, 1999 through December 31, 2003.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard HMO Plans, co-payment schedules and schedules of benefits;
- The Company's most commonly sold HMO group certificates.
- The Company's HMO conversion certificates, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee HMO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Division between January 1, 2006 and December 31, 2006.

New Business Applications and Renewals

The examiners reviewed:

- A sample of fifty (50) small group new business application files;
- A sample of fifty (50) small group renewal files; and
- The Company's rating of both small group new business application files and renewals was reviewed from the above two samples of files.

Cancellations/Terminations/Declinations

The examiners reviewed a random sample of fifty (50) involuntary cancellations and voluntary termination files from the total population of 230 such files. The sample size was reduced to forty-six (46) due to duplicate files and files with termination dates outside the scope of the examination that were discovered in the sample.

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law, as well as the proper and accurate payment of claims, the examiners reviewed the following random samples:

- Fifty (50) electronic claims paid or denied beyond thirty (30) days;
- Fifty (50) non-electronic claims paid or denied beyond forty-five(45) days;
- Fifty (50) claims paid or denied beyond ninety (90) days; and
- Fifty (50) paid and denied claims that were reviewed for accuracy of payment.

Utilization Review

The findings of the utilization review portion of the HMOC examination report are "deemed" to also apply to the Rocky Mountain Hospital and Medical Service, Inc. report. The examiners reviewed copies of the Company's Appeals Guide along with its utilization review policies and procedures, and the following random samples and/or entire populations of utilization review files in order to determine compliance with Colorado insurance law:

- Fifty (50) utilization review approval files;
- Fifty (50) utilization review denial files;
- Fifty (50) first level utilization review appeal files;
- The entire population of eight (8) voluntary second level utilization review appeal files.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of seventeen (17) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings.

Company Operations and Management: The examiners identified two (2) areas of concern in their review of the Company's operations and management.

Issue A1: Failure of the Company, in some instances, to include all required contract provisions in provider contracts.

Issue A2: Failure of the Company to maintain records required for market conduct purposes.

Contract Forms: The examiners identified seven (7) areas of concern in their review of the Company's contract forms.

Issue E1: Failure of the Company's forms, in some instances, to provide coverage for newborns to the extent required by Colorado insurance law.

Issue E2: Failure of the Company's forms to correctly disclose the policies and procedures for obtaining emergency medical services.

Issue E3: Failure of the Company's forms, in some instances, to provide accurate information regarding coordination of benefits with Medicare.

Issue E4: Failure of the Company's forms, in some instances, to provide for continuation of coverage when a member becomes entitled to Medicare benefits.

Issue E5: Failure to correctly title the Basic and Standard health benefit plan certificates.

Issue E6: Failure, in some cases, to include only required benefits in the Basic and Standard health benefit plan forms.

Issue E7: Failure, in some cases, to include a correct description of the preventive services required in the Basic and Standard health benefit plans.

New Business Applications and Renewals: The examiners identified one (1) area of concern in their review of the new business and renewal handling practices of the Company.

Issue G1: Failure, in some instances, to obtain and retain in the file a list of eligible employees and/or eligible dependents.

Cancellations/Declinations/Terminations: The examiners identified three (3) areas of concern in their review of the cancellation/declination/termination practices of the Company.

Issue H1: Failure to include the full definition of "significant break in coverage" in certificates of creditable coverage.

Issue H2: Failure, in some instances, to implement procedures for terminating policies, including coding and timing of cancellation processing, and providing offers of Basic and Standard coverage that are in compliance with Colorado insurance law.

Issue H3: Failure to include the required elements and information in certificates of creditable coverage.

Claims: The examiners identified two (2) areas of concern in their review of the claims handling practices of the Company.

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay penalties on claims not paid within the time frames required by Colorado insurance law.

Utilization Review: The examiners identified two (2) areas of concern in their review of the Company's utilization review procedures.

Issue K1: Failure, in some instances, to provide written notification of first level review adverse determinations within the time frame required by Colorado insurance law.

Issue K2: Failure to provide the location of the review panel meeting and thereby discouraging the covered person from requesting a face-to-face meeting.

A copy of the Company's response, if applicable, can be obtained by contacting the Company. Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

HMO COLORADO, INC

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure of the Company, in some instances, to include all required contract provisions in provider contracts.

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, states in part:

(1) In addition to any other applicable requirements of this part 7, a carrier offering a managed care plan shall satisfy all the requirements of this section.

(4)(a) Every contract between a carrier and a participating provider shall include provisions for continuity of care as specified in this subsection (4).

(b) Each managed care plan shall allow covered persons to continue receiving care for sixty days from the date a participating provider is terminated by the plan without cause when proper notice as specified in subsection (7) of this section has not been provided to the covered person.

(c) In the circumstance that coverage is terminated for any reason other than nonpayment of premium, fraud, or abuse, *every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged*.

(11) A carrier shall not penalize a provider because the participating provider, in good faith, reports to state or federal authorities any act or practice by the carrier that jeopardizes patient health or welfare, or *because the participating provider discusses the financial incentives or financial arrangements between the provider and the managed care plan*.

(14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(a) *A provision that clearly states that the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person*; and

(b) *A provision that allows a covered person to receive a standing referral, as defined in section 10-16-102(43.5) for medically necessary treatment, to a specialist or specialized treatment center participating in the carrier's network or participating in a subdivision or subgrouping of the carrier's network if the subdivision or subgrouping demonstrates network adequacy pursuant to section 10-16-704*. The primary care provider for the covered person, in consultation with the specialist and the covered person, shall determine that the covered person needs ongoing care from the specialist in order to make the standing referral. A time period for the standing referral of up to one year, or a longer period of time if authorized by the carrier or any entity that contracts with the carrier, shall be determined by the primary care provider in consultation with the specialist or specialized treatment center.

> The specialist or specialized treatment center shall refer the covered person back to the primary care provider for primary care. To be reimbursed by the carrier or entity contracting with the carrier, treatment provided by the specialist shall be for a covered person and must comply with provisions contained in the covered person's certificate or policy. The primary care physician shall record the reason, diagnosis, or treatment plan necessitating the standing referral. [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its provider contracts:

1) Do not clearly state that the sole responsibility for obtaining any required pre-authorization rests with the provider, and not with the Member;

2) Provide for continued care and services only for Members confined to a hospital. This is a more restrictive requirement than "in-patient facility" set forth in Colorado insurance law. Additionally, the Company's contract does not provide a definition of "hospital" that would include all in-patient facilities;

3) Prohibit the provider from discussing specific payment arrangements, including dollar amounts, with a Member;

The Company's contract states, in part, the following:

ARTICLE II. OBLIGATIONS OF PRIMARY CARE PROVIDER

E. Admissions. Any non-Emergency inpatient admission of, or use of an outpatient surgery facility by, a Member must be approved in advance by HMOC. *The attending physician shall be responsible for obtaining HMOC authorization for such admissions. However, this provision is not intended to relieve Member of any responsibility under the Membership Certificate.*

ARTICLE VI. TERM AND TERMINATION

E.3. Participating Provider shall, upon termination of this Agreement for reasons other than the grounds set forth in the termination for default Section of this Agreement, continue to provide and be compensated for Covered Services to Members under the terms and conditions of this Agreement for 60 days after the effective date of such termination. If coverage is terminated for any reason other than nonpayment of premium, fraud, or abuse, Primary Care Provider shall continue to provide and be compensated for Covered Services to Members under the terms and conditions of this Agreement *until such Members are discharged from the hospital. For purposes of this Section, "discharge" shall mean the Member's physical release from Hospital*.

ARTICLE VII. MISCELLANEOUS PROVISIONS

P. Medical Care Decisions. …Nothing in this Agreement shall prohibit the Primary Care Provider from disclosing the general methodology by which Primary Care Provider is compensated under this Agreement, *provided no dollar amounts or other specific terms of the payment arrangement are mentioned to the Member*. [Emphases added.]

Form	Form Number
Primary Care Provider Agreement	PCP FFS: 10/2005

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-705, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its provider contracts to comply with Colorado insurance law.

Issue A2: Failure of the Company to maintain records required for market conduct purposes.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states, in part:

(4) Special provisions for small group health benefit plans.

(a) Effective January 1, 1995, *each small employer carrier shall, upon termination of a group policy by the carrier or employer* for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, *offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection* (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, *cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.*

(b) If the group's original plan had benefits which were significantly less generous in most respects than the standard plan as determined by the commissioner, the carrier is only required to offer the basic health benefit plan to such group or individual. If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of paragraph (a) of this subsection (4) and this paragraph (b) shall not apply to such an individual.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of Section 10-1-109(1), C.R.S., states in part:

Section 4. Records Required For Market Conduct

A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to,* company operations and management, *policyholder services,* claims practices, *rating, underwriting,* marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two calendar years.

Section 5. Policy Records

A. The following records shall be maintained: *A policy record shall be maintained for each policy issued. Policy records shall be maintained so as to show clearly the policy period, basis for rating* and any imposition of additional exclusions from or exceptions to coverage. If a policy is terminated, either by the insurer or the policyholder, documentation

supporting the termination and account records indicating a return of premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of other states so long as they are readily available to market conduct examiners as required under this regulation.

B. Policy records shall include at least the following:

(1) *The actual, completed application for each contract, where applicable;*

(a) The application shall bear the signature, either written or digitally authenticated, where required, of the applicant whenever the insurer intends to retain any right to contest any warranty, representation or condition contained in the application; or

(b) The application shall bear a clearly legible means by which an examiner can identify a producer involved in the transaction. The examiners shall be provided with any information needed to determine the identity of the producer;

(2) *Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, any termination notices, and any written or electronic correspondence to or from the insured pertaining to the coverage.* A separate copy of the record need not be maintained in the individual policy to which the record pertains, provided it is clear from the insurer's other records or systems that the record applies to a particular policy and that any data contained in the record relating to that policy, as well as the actual policy, can be retrieved or recreated;

(3) Any binder with terms and conditions that differ from the terms and conditions of the policy subsequently issued; and

(4) *Any guidelines, manuals or other information necessary for the reconstruction of the rating, underwriting, and claims handling of the policy.* Presentation at the site of a market conduct examination of a single copy of each of the above shall satisfy this requirement. *If a rating, underwriting, or claims handling record is computer based, the records used to input the information into the computer system shall also be available to the examiners. These types of records include, but are not limited to, the application, where applicable, the policy form including any amendments or endorsements, rating manuals, underwriting rules, credit reports or scores, claims history reports, previous insurance coverage reports, e.g., MIB questionnaires, internal reports, loans and underwriting and rating notes.* [Emphases added.]

SMALL GROUP CANCELLATION FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
230	46	46	100%

A random sample of fifty (50) small group cancellation files was selected for review. Four (4) files were excluded because they were either duplicates or outside the examination scope.

It appears that the Company is not in compliance with Colorado insurance law in that it was unable to provide copies of the cancellation notices for any of the forty-six (46) files in the cancellation sample. Therefore, the examiners were unable to determine compliance with the requirement that the Company offer a Basic or Standard health benefit plan to each individual upon cancellation of the group health benefit plan.

The Company was also unable to provide copies of the certificates of creditable coverage that are required when coverage is cancelled. The examiners reviewed regenerated copies of certificates of creditable coverage for twenty-four (24) of those forty-six (46) files. The Company indicated it could not provide certificates for the remaining twenty-two (22) files. The regenerated copies have 2007 and 2008 issue dates on them as the Company stated it can reproduce and provide copies only with current dates. The Company also stated it was unable to provide actual copies or copies regenerated with the actual dates the certificates were mailed.

RENEWAL FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,012	50	44	88%

In addition, forty-four (44) of the fifty (50) files in the renewal file sample were missing some or all of the renewal information. Some of the missing information included but was not limited to, the insurance contract and certificates of coverage when there had been a plan change, information necessary for reconstruction of the rating, final rates and signed acceptance, etc.

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R. S. and Colorado Insurance Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its record maintenance procedures to ensure that all records required for market conduct purposes are maintained and can be provided within the time periods required by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure of the Company's forms, in some instances, to provide coverage for newborns to the extent required by Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(3)(a) Maternity coverage.

(IV) The provisions of subparagraphs (II) and (III) of this paragraph (a) shall not apply in any case in which the decision to discharge the newborn prior to the minimum length of stay otherwise required under subparagraphs (II) and (III) of this paragraph (a) *is made by an attending physician with the agreement of the mother*. [Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that some certificate forms fail to require the agreement of the mother in order to discharge the newborn prior to the minimum length of stay otherwise required under subparagraphs (II) and (III). The Company's certificate forms listed below state the decision to shorten the period of inpatient care is to be made by the attending physician after consulting with the mother.

These certificate forms state, in part, the following:

Member Benefits

Maternity and Newborn Care

HMO Colorado will not limit coverage for a hospital stay in connection with childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning following the 48-hour or 96-hour coverage period. The mother's attending physician, after consulting with the mother, may discharge the mother and newborn child earlier if appropriate.

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Form	Form Number
HMO Standard	98500_HMO Standard (Rev. 1-06) v2
HMO Basic for Group	98700_HMO Basic (REV. 1-06) v1
HMO Basic Group Conversion	98700_GC (Rev.1-06) v2
HMO Standard Group Conversion	98500_GC (Rev. 1-06) v2

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to ensure that newborn care is covered as required by Colorado insurance law.

Issue E2: Failure of the Company's forms to correctly disclose the policies and procedures for obtaining emergency medical services.

Section 10-16-407, C.R.S., Information to enrollees, states in part:

> (2) Every health maintenance organization shall clearly state in its brochures, contracts, policy manuals, and printed materials distributed to enrollees that such enrollees shall have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever an enrollee is confronted with a life or limb threatening emergency. For the purposes of this section, a "life or limb threatening emergency" means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. *No enrollee shall in any way be discouraged from using the local prehospital emergency medical service system, the 9-1-1 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such use in a life or limb threatening emergency.* [Emphasis added.]

Colorado Emergency Insurance Regulation 05-E-5, and Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S., state in part:

> Section 4. Definitions
>
> H. "Emergency medical condition" means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment of bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
>
> K. "Life or limb threatening emergency" shall have the same meaning as defined in Section 10-16-407(2), C.R.S.
>
> Section 8. Emergency Services
>
> A. *A health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.* Under these same circumstances, a claim for emergency medical services necessary to screen and stabilize a covered person shall not be denied for failure of the covered person or emergency service provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall not deny a claim for emergency medical services necessary to screen and stabilize a covered person and shall not require prior

> authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider. [Emphases added]

Colorado Insurance Regulation 4-7-2, Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated pursuant to 10-16-109, C.R.S., states in part:

> Section 4 Definitions
>
> No contract or evidence of coverage delivered or issued for delivery to any person by an HMO required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below and in § 10-16-102, C.R.S. unless such definitions comply with the requirements of this section. Definitions other than those set forth herein and in § 10-16-102, C.R.S. may be used as appropriate providing that they do not contradict these requirements. As used in this regulation and for the purpose of any terms used in a benefit contract of evidence of coverage:
>
> C. "Emergency services" means health care services provided in connection with an event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms provide that the Company will decide if emergency or urgent care services, supplies, conditions, situations or charges are medically necessary.

The Company's certificate language contains provisions that are confusing and contradictory, and as such, could be confusing to Member's when trying to obtain emergency medical services.

The Company's Premier HMO certificate states, in part, the following:

Covered Services

Emergency Care and Urgent Care

Benefits in this section are subject to the GENERAL EXCLUSIONS section of the Certificate

General Exclusions

We do not provide benefits for services, supplies, conditions, situations or charges:

1. That We determine are not Medically Necessary;

Form	**Form Number**
Premier HMO	98888 smg (11-05)

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-407, C.R.S., and Colorado Insurance Regulations 05-E-5, 4-2-17 and 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to correctly disclose and define its policies and procedures for obtaining emergency medical services as required by Colorado insurance law.

Issue E3: Failure of the Company's forms, in some instances, to provide accurate information regarding coordination of benefits with Medicare.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(f)(II) *Making or permitting any unfair discrimination between individuals of the same class* or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charges for any policy or contract of insurance, or *in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;* [Emphasis added.]

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(4) Low-dose mammography.

(a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and *all* individual and *group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article,* as well as any other group health care coverage provided to residents of this state, *shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. …*

(5) Mental illness.

(g) *Every group health care service plan providing hospitalization or medical benefits under the provisions of part 4 of this article shall provide benefits for conditions arising from mental illness at least equal to the benefits required by this subsection (5).* The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (5) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(5.5) Biologically based mental illness.

(a)(I)*Every group policy, plan certificate, and contract of a carrier subject to the provisions of part* 2, 3, or *4, of this article,* except those described in section 10-16-102(21)(b), *shall provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for any other physical illness.*

(10) Prostate cancer screening.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and *all* individual and *group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article,* as well as any other group health care coverage offered to residents of this state, *shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories,* which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. [Emphases added.]

Colorado Insurance Regulation 4-6-2, Group Coordination of Benefits, states in part:

Section 4. Definitions

As used in this regulation, these words and terms have the following meanings:

H. "Plan" means a form of coverage with which coordination is allowed or required. The definition of plan in the group contract must state the types of coverage that will be considered in applying the COB provisions of that contract. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(3) Plan may include:

(h) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(i) below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

Section 5. Use of Model COB Contract Provision

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(1) Another plan exists and the covered person did not enroll in that plan;

(2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; …

Colorado Insurance Regulation 4-7-2, Concerning The Laws Regulating Health Maintenance Organization Benefit Contracts And Services In Colorado, states in part:

Section 5. Requirements for Benefit Contracts and Evidences of Coverage

Each enrollee shall be entitled to receive an individual contract and/or evidence of coverage. …The contract and/or evidence of coverage shall include the following:

L. Coordination of Benefits

A group contract and/or evidence of coverage must contain a provision for coordination of benefits that shall be consistent with Colorado Insurance Regulation 4-6-2, 3CCR 702-4. …

It appears that the Company is not in compliance with Colorado insurance law in that its Premier/Classic HMO certificate forms exclude coverage for benefits that are payable under Medicare Part A and/or Medicare Part B or that would have been payable if the enrollee had applied for Part A and/or Part B. Colorado law requires HMO's to coordinate benefits when there is duplicate coverage (including Medicare) for services covered by the member's HMO coverage. In addition, carriers cannot exclude (or coordinate) coverage for services which would have been covered by Medicare Part A or Part B simply because the member was eligible for such coverage, but had not applied for it.

The Company's Certificate states in part:

Covered Services

Preventive Care Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Routine/Preventive Diagnostic Services

- One routine screening mammogram is covered per Benefit Period regardless of age or in accordance with the frequency determine by your provider;

- One routine prostate specific antigen (PSA) blood test and digital rectal examination are covered per Benefit Period regardless of age or in accordance with the frequency determined by your Provider;

And,

Mental Health Care Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

General Exclusions

We do not provide benefits for services, supplies, conditions, situations or charges:

6. For which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if you had applied for Part A and/or Part B, unless otherwise specified in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled **Medicare** in **ADMINISTRATIVE INFORMATION**;

Administrative Information

General Provisions

Medicare – Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions, and federal law. Except when federal law require (sic) Us to be the primary payor, the benefits under this Certificate if you are age 65 and older, or if you are otherwise eligible for Medicare, do not duplicate any benefit for which you are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to Us, to the extent We have made payment for such services.

Form	Form Number
Premier/Classic HMO	98888_smg (11-05)

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-104, C.R.S., and Colorado Insurance Regulations 4-6-2 and 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to provide accurate information regarding coordination of benefits with Medicare to comply with Colorado insurance law.

Issue E4: Failure of the Company's forms, in some instances, to provide for continuation of coverage when a member becomes entitled to Medicare benefits.

Section 10-16-108, Conversion and continuation privileges, states, in part:

(2) Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.

(a) Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by a nonprofit hospital, medical-surgical, and health service corporation or a health maintenance organization operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).

(b)(III) The employer shall not be required to *offer* continuation of coverage of any person if such person is covered by medicare, Title XVIII of the federal "Social Security Act", or medicaid, Title XIX of the federal "Social Security Act".

(c)(I) Upon the termination of employment of an eligible employee, the death of any such employee, or the change in marital status of any such employee, *the employee or dependent has the right to continue the coverage for a period of eighteen months after loss of coverage or until the employee or dependent becomes eligible for other group coverage,* whichever occurs first. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen months or until the new plan covers the condition, whichever occurs first. [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its contract forms provide that continuation coverage will terminate when the Member becomes entitled to Medicare benefits.

Colorado insurance law states that an offer of continuation of coverage need not be extended if the Member is already covered by Medicare or Medicaid when they become eligible for continuation of coverage. However, as neither Medicare nor Medicaid is "group" coverage, the carrier is not allowed to terminate coverage solely because a member becomes eligible for and/or covered by Medicare or Medicaid while on continuation of coverage.

The Company's contract forms state, in part, the following:

Termination of State Continuation Coverage or COBRA

Continuation coverage may terminate before the continuation period expires if:

- You become covered by Medicare

Form	Form Number
Premier HMO, Classic HMO Premier – HMO1 Premier HMO Select, Classic HMO Select – HMO Select 2 for Small Group	98888_smg (11-05)
HMO Basic for Group	98700_HMO Basic (Rev. 1-06) v1
HMO Standard	98500_HMO Standard (Rev. 1-06) v2

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to provide for continuation of coverage when a Member becomes entitled to Medicare to comply with Colorado insurance law.

Issue E5: Failure to correctly title the Basic and Standard health benefit plan certificates.

Colorado Insurance Regulation 4-6-5, CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS, promulgated pursuant to §§10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

4. Rules

   A. Plans

      1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S. and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

      2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

   B. *The basic and standard health benefit plans shall be identified as specified below.*

      1. Each small employer carrier *shall title* and market its basic health benefit plan as follows: "[Carrier name][Type of plan (i.e., Indemnity, Preferred Provider or HMO) (*Basic Limited Mandate Health Benefit Plan, Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan*)] *for Colorado*."

      2. Each small employer carrier *shall title* and market the standard health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO] *Standard Health Benefit Plan for Colorado*." [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its Basic and Standard health benefit plan contract forms are not correctly titled pursuant to the Colorado Insurance Regulation 4-6-5. The health plan description forms issued in conjunction with the Company's Basic and Standard health benefit plan contracts also fail to reflect the correct titling as required by Colorado insurance law.

The Company's Basic and Standard health benefit plan contracts (and health plan description forms) are titled as listed below. The "Basic" plan titles do not reflect the titling required by Colorado insurance law and do not allow the Examiners, nor the Members, to determine which of the three (3) designated Basic health benefit plans are being offered. The "Standard" health benefit plan does not reflect the complete title required by Colorado Insurance law.

Form	Form Number
HMO Standard	98500_HMO Standard (Rev. 1-06) v2
HMO Standard BA84 CX11 05-01-06	98027 (Rev. 4-06) v1 x6
HMO Basic for Group	98700_HMO Basic (Rev. 1-06) v1
HMO Basic BA83 CX27 05-01-06	98026 (Rev. 4-06) v1 x5

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado insurance regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to reflect correct titles for the Basic and Standard health benefit plan certificates to comply with Colorado insurance law.

Issue E6: Failure, in some cases, to include only required benefits in the Basic and Standard health benefit plan forms.

Colorado Insurance Regulation 4-6-5, CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".*

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan.*"

5. *All basic and standard health benefit plans shall also comply with the following requirements:*

   B. **Benefit Modifications:** *The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only.* [Emphases added.]

Benefit Grids:

JANUARY 1, 2006 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
29. VISION CARE	No coverage	No coverage	No coverage	No coverage

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
29. VISION CARE	No Coverage	No coverage	No coverage	No coverage

It appears that the Company is not in compliance with Colorado insurance law in that the description of covered services contained in the Company's health plan description forms indicates coverage is provided for routine eye exams. The inclusion of coverage for routine eye exams appears to represent an enhancement of additional coverage that is not to be included in the Colorado Basic and Standard health benefit plans except through a rider or endorsement at the option of the policyholder only.

The examiners note that the Company's Basic and Standard health benefit plan contract forms do contain an exclusion of coverage for other vision services, but do not appear to specifically address "routine eye exams". This is misleading and confusing to the Member with regard to their benefits.

The Company's contract forms state, in part, the following:

General Exclusions

Vision – This coverage does not cover any eyeglasses, contact lenses (even if there is a medical diagnosis that prevents a member from wearing eyeglasses) or prescriptions for such services and supplies. This coverage does not cover any surgical, medical or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness or astigmatism. This coverage does not cover vision therapy, including, but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.

The Company's health plan description forms state in part, the following:

29. VISION CARE	No Coverage, except for routine eye exams every 24 months

Form	Form Number
HMO Standard BA84	98500_HMO Standard (Rev. 1-06) v2
Standard HMO Health Benefit Plan BA84 CX11	98027 (Rev. 4-06) v1 x6 05-01-06
HMO Basic for Group BA83	98700_HMO Basic (Rev. 1-06) v1
Basic HMO Health Benefit Plan	98026 (Rev. 04-06) v1 x5

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado insurance regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to include only required benefits in the Basic and Standard health benefit plan forms to comply with Colorado insurance law.

Issue E7: Failure, in some cases, to include a correct description of the preventive services required in the Basic and Standard health benefit plans.

Colorado Insurance Regulation 4-6-5, CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective January 1, 2006, states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".*

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan.*" [Emphases added.]

Benefit Grids:

JANUARY 1, 2006 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**

9. PREVENTIVE CARE[6]	For all plans, only specified preventive services are covered.			
a) **Children's services** (No deductible prior to application of co-insurance.)	50% coinsurance	$40 copay/visit.	50% coinsurance	$40 copay/visit.
b) Adults' services[6a]	50% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit.

6 See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

6a Prostate cancer screening and routine mammograms are not covered.

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
	For all plans, only specified preventative services are covered.			
9. PREVENTIVE CARE[6]				
a) **Children's services** (No deductible prior to application of coinsurance.)	80% coinsurance	$25 copay/visit.	50% coinsurance	$25 copay/visit.
b) **Adult's services**	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit

6 See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

Attachment 1

Covered Preventive Services [1]	
All Persons	1 smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed $150 payment by insurer.
	Chicken pox vaccination for all persons who have not had chicken pox.
All Children	Immunizations. Immunization deficient children are not bound by "recommended ages".
Age 0 – 12 Months	1 newborn home visit during first week of life if newborn is released from hospital less than 48 hours after delivery.
	5 well-child visits[2]
	1 PKU
Age 13 – 35 Months	2 well-child visits
Age 3 - 6	3 well-child visits
Age 7 – 12	3 well-child visits
Age 13 - 18	1 age appropriate health maintenance visit[3] every year
	1 Td
	Females: screening pap smears not to exceed 1 per year
	1 hepatitis B vaccination if not given previously

2. "Well-child visit means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

3. "Age appropriate health maintenance visit" means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutritional counseling (including foliate counseling for women of child bearing age).

It appears that the Company is not in compliance with Colorado insurance law in that the description of preventive care services for children contained in the Company's "HMO Basic for Group", "HMO Basic Group Conversion", "HMO Standard" and "HMO Standard Group Conversion" health benefit plan contracts do not correctly list the age categories for covered preventive services mandated under Colorado Insurance Regulation 4-6-5. Additionally, neither the Company's Basic or Standard health benefit plan contracts provide the definition of what is included with the "well-child" or "age appropriate" health maintenance visits.

The Company's HMO Basic and Standard contracts state, in part, the following:

Preventive Care Services

Children

All Children

- One smoking cessation education program under physician supervision or as authorized by HMO Colorado per member's lifetime, not to exceed $150
- Chicken pox vaccination for any member who has not previously had chicken pox

All children aged 0 – 18 years

- Routine immunizations, including annual flu immunization
- Vision and hearing screenings when administered by the member's PCP as part of a preventive office visit

Age 0 – 11 Months

- 6 well-child visits
- One newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hour after delivery
- One PKU (phenylketonuria) test

Age 12 -23 Months

- Three well-child visits

Age 2 – 6 years

- One well-child visit

Age 7-12

- Three well-child visits

Age 13 – 18 years

- One age appropriate health maintenance visit every calendar year
- One Pap test every year for females

Age 13 – 18 years

- Annual pelvic examination and Pap test

Form	Form Number
HMO Basic for Group BA83	98700_HMO Basic (Rev. 1-06) v1
HMO Standard BA84	98500_HMO Standard (Rev. 1-06) v2
HMO Basic Group Conversion CX27	98700_GC (Rev. 1-06) v2

HMO Standard Group Conversion CX11 98500_GC (Rev. 1-06) v2

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado insurance regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to include a correct description of the preventive services required in the Basic and Standard health benefit plans to comply with Colorado insurance law.

NEW BUSINESS APPLICATIONS AND RENEWALS

Note: Some of the findings in the New Business Applications and Renewals Section were deemed to also apply to the market conduct examination of Rocky Mountain Hospital and Medical Service, Inc.

Issue G1: Failure, in some instances, to obtain and retain in the file a list of eligible employees and/or eligible dependents.

Colorado Insurance Regulation 4-6-8, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-16-105.2(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S., states in part:

> Section 5. Issuance Of Coverage
>
> B. Determining Who is an Eligible Employee, Dependent
>
> (2) *A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list.* The small employer carrier may require the small employer to provide appropriate supporting documentation, such as the Unemployment Insurance Quarterly Wage and Tax Report (UITR) often referred to as a W-2 Summary Wage and Tax Form, to verify the information required under this paragraph. In the event that a UITR form is not available because the employer was not in business during the preceding quarter or the employer has outsourced payroll functions, the carrier shall accept reasonable alternate documentation for this information. Alternate documentation includes, but is not limited to, payroll documentation from the company or the company's payroll administrator or employee leasing company; organizational documents; or other reasonable proof. [Emphasis added.]

SMALL GROUP NEW BUSINESS APPLICATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,104	50	24	48%

The examiners reviewed a randomly selected sample of fifty (50) files from a summarized population of 1,104 new small groups issued during the examination period. Based on the files examined it appears that the Company is not in compliance with Colorado insurance law in that twenty-four (24) of the sample files did not contain a list of eligible employees and/or eligible dependents.

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado insurance regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to include obtaining and retaining a list of eligible employees and dependents with each new application to comply with Colorado insurance law.

CANCELLATIONS/DECLINATIONS/TERMINATIONS

Issue H1: Failure to include the full definition of "significant break in coverage" in certificates of creditable coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1)(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule*. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 4. Definitions

A. “Significant break in coverage” means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

3. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

4. Certifying creditable coverage

   Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance *must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphasis added]

It appears the Company is not in compliance with Colorado insurance law in that its notice titled "Certificate of Creditable Coverage" consisting of three pages doesn't reflect the full definition of "significant break in coverage" as provided in Section 4. A. of Colorado Insurance Regulation 4-2-18. The Company initially provided two examples of the notice and then provided regenerated copies of the designated sample policies. Although the Company's form does include a parenthetical reference to a definition, the form doesn't include the entire definition which clarifies that locations outside the jurisdiction of Colorado may have a different definition of a "significant break in coverage".

The Company's Certificate states in part:

> Preexisting condition exclusions
>
> You can add up any creditable coverage you have had, including the coverage shown on this certificate. However, if at any time you went for 90 days or more without any coverage (called a significant break in coverage) a plan may not have to count the coverage you had before the break.
>
> Therefore, once your coverage ends, you should try to obtain alternative creditable coverage as soon as possible to avoid a 90-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Form	Form Number
Certificate of Creditable Coverage	10340E 09/19/05

Recommendation 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. and Colorado insurance regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificate of creditable coverage to comply with Colorado insurance law.

Issue H2: Failure, in some instances, to implement procedures for terminating policies, including coding and timing of cancellation processing, and providing offers of Basic and Standard coverage that are in compliance with Colorado insurance law.

Section 10-16-102, C.R.S., Definitions states, in part:

(21)(a) "Health benefit plan" means any hospital or medical expense policy or certificate, hospital or medical service corporation contract, or *health maintenance organization subscriber contract* or any other similar health contract subject to the jurisdiction of the commissioner available for use, offered, or sold in Colorado.

(26) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. *An eligible employee or dependent shall not be considered a late enrollee if:*

(a) The individual:

(III) Requests enrollment within thirty days after termination of the other creditable coverage; or

(d) A person becomes a dependent of a covered person through marriage, birth, adoption, or placement for adoption and requests enrollment *no later than thirty days after becoming such a dependent.* In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

(4) Special provisions for small group health benefit plans.

(a) Effective January 1, 1995, *each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.*

(b) If the group's original plan had benefits which were significantly less generous in most respects than the standard plan as determined by the commissioner, the carrier is only required to offer the basic health benefit plan to such group or individual. If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of paragraph

(a) of this subsection (4) and this paragraph (b) shall not apply to such an individual.

(c) *Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; …*

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) *Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage.* The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule.

(c) *Shall exclude coverage for late enrollees for the greater of twelve months or for no more than an eighteen-month-preexisting condition exclusion; except that, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.* Health maintenance organizations that do not use preexisting condition exclusion periods in any of their plans may impose up to a three-month affiliation period in lieu of the eighteen-month preexisting condition period. [Emphases added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 4.Definitions

B. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.*

Section 5. Rules

B. Colorado law concerning creditable coverage.

5. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

6. *Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.*

7. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

C. Maximum six (6) month pre-existing condition exclusion period for group health plans.

Colorado law prohibits group health plans from imposing a pre-existing condition limitation period that exceeds six (6) months, except with respect to late enrollees as provided for in Section 10-16-118(1)(c), C.R.S. All references in the federal regulations to twelve (12) month pre-existing condition limitations for group health benefit plans are not applicable in Colorado.

D. Student health plans are considered group health plans.

Colorado law considers student health benefit plans to be group plans. *As such, student health plans shall comply with the group health benefit plan provisions of Colorado law including those related to pre-existing condition limitations.*

E. Children's Basic Health Plan is considered a group health plan.

Colorado law considers the Children's Basic Health Plan (also known as CHP+) to be a group plan. *As such, carriers offering coverage through the Children's Basic Health Plan shall comply with the group health benefit plan provisions of Colorado law.*

F. Treatment of late enrollees.

Colorado law requires late enrollees (i.e., those individuals who did not enroll when initially offered coverage and who are not special enrollees pursuant to section 10-16-102(26), C.R.S.) to be enrolled upon request. *However, late enrollees are subject to longer pre-existing condition periods, affiliation periods, and waiting periods for coverage, as provided for in Section 10-16-118(1)(c), C.R.S.*

HMO CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
230	46	46	100%

The examiners reviewed a total of forty-six (46) cancellation files randomly selected from a total population of 230 files. This included a second sample requested after the examiners determined the first sample included forty-one (41) files that appeared to be conversions to other plans or groups rather than cancellations (some of which were still active), and files with cancellation effective dates outside the time frame of the examination. The second sample included one (1) file that was a duplicate of a file from the first sample, and three (3) of the original sample files retained were found to have cancellation dates effective outside the examination period. Therefore, these four (4) files were excluded from the sample which resulted in the adjusted sample of forty-six (46) files reviewed.

It appears the Company's procedures for terminating policies, including coding and timing of cancellation processing, and providing offers of basic and standard coverage are not in compliance with Colorado insurance law in several ways:

Issue 1: The examiner was unable to find documentation in any of the forty-six (46) files to determine whether an offer of basic or standard coverage was made for those policies cancelled due to:

(1) the group no longer meeting group requirements,
(2) non-payment of premium,
(3) policyholder exercising the right to cancel and not replace with another group policy.

Failure to provide documentation in each case supporting that either basic or standard coverage was offered appears to be a lack of compliance with the required offer.

Issue 2: It appears the Company has recorded contradictory information and coded reasons for cancellation incorrectly. This appears to have resulted in the Company's failure to provide required offers of basic or standard coverage in some situations. The Company provided screen prints, documentation, and/or a code on a spreadsheet which contradicted each other and/or the explanatory information the Company provided regarding the definitions of cancellation reason codes. The examiner is unable to determine in some cases from the contradictory information and lack of other supporting information, whether offers of basic or standard coverage were required, or were sent when required.

Six (6) of the forty-six (46) files contained discrepancies between the reason codes indicated on the screen prints, the reason codes indicated in the spreadsheet, and when provided, separate documentation of reasons for cancellation in the system file notes or written communications.

- Three (3) of the six (6) files indicated reason code "89" - "group request"; however, file documentation indicates the policy should have been coded "47" or "DU" - cancellation for non-payment of premium, which requires an offer of basic or standard coverage,

- One (1) file indicted reason code "47" or "DU" – cancellation for non-payment of premium or 19 WLP Conversion; however, documentation provided indicates the policy should have been coded "89" - "group request", which may have required an offer of basic or standard coverage,

- One (1) file indicated reason code "89" – "group request", while documentation indicated the policy should have been cancelled with reason code "28" - "no longer qualifies as a group", which requires an offer of basic or standard coverage,

- One (1) file indicated the cancellation effective date as 30 days prior to the date the member requested.

Issue 3: It appears that in some cases, the Company has terminated policies retroactively in violation of Colorado insurance laws. In twenty-seven (27) of the forty-six (46) files, terminations were processed more than thirty (30) days after the termination effective date. The time periods ranged from thirty-five (35) days to three hundred and fifteen (315) days after the termination effective date, and included twenty-one (21) policies for which terminations were processed ninety (90) days or more after the effective date. These delays in processing may have caused a significant break in coverage for the members of these twenty-one (21) groups.

When a contract is terminated thirty (30) or more days retroactively, the member cannot be aware of the default in sufficient time to exercise his or her right to elect any alternative coverage to which he or she would otherwise be entitled whether through the carrier via or another carrier through another group or individual plan. In addition, in all likelihood the member has already paid premium to the defaulting employer for the terminated group coverage, and would most likely have to pay additional premium for any alternative coverage he or she may be entitled to.

To summarize, a member who is not given sufficient advance notice of termination of the group contract so that application for alternative coverage can be made within any applicable time frame:

- May lose the right to guaranteed issuance of alternative group health coverage upon the occurrence of, for example, a change in family status;

- May lose the right as a federally eligible individual to guaranteed issuance of an individual policy;

- May be considered a late applicant subject to a pre-existing condition limitation under a new policy or contract; and

- May incur health care expenses after paying his or her premium contribution believing in good faith that health coverage is in force, only to find out later that he or she is liable for those medical costs.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-108, 10-16-118, C.R.S. and Colorado insurance regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its termination procedures to comply with Colorado insurance law.

Issue H3: Failure to include the required elements and information in certificates of creditable coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule.* [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to *ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.*

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., *shall be as set forth in the federal regulations incorporated below.*

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, *Colorado law shall prevail.*

3. *The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.:*

45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). These sections concern the method for counting creditable

coverage; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates.

B. Colorado law concerning creditable coverage.

8. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

9. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation. [Emphases added]

45 C.F.R. 146.113 Rules relating to creditable coverage.

(a) General rules.

(1) Creditable Coverage. For purposes of this section, except as provided in paragraph (a)(2) of this section, *the term creditable coverage means coverage of an individual under any of the following:*

(i) A group health plan as defined in Sec. 146.145(a).

(2) Counting creditable coverage

(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual *the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage.* Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) Days not counted before a significant break in coverage. Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

45 C.F.R. 146.115 Certification and disclosure of previous coverage, states in part:

(a) Certificate of creditable coverage

(1) Entities required to provide certificate

(i) In General. A group health plan, and each health insurance carrier offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(2) *Individuals for whom certificate must be provided*; timing of issuance

(i) Individuals. *A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii)* or (iii) of this section.

(ii) Issuance of automatic certificates. *The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.*

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, *an automatic certificate must be provided at the time the individual ceases to be covered under the plan* A plan or issuer satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate *within a reasonable time after coverage ceases* (or after the expiration of any grace period for nonpayment of premiums).

(3) Form and content of certificate.

(i) Written certificate.

(A) In General. Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (or any other medium approved by the Secretary).

(ii) Required information. The certificate must include the following

(C) The name of the participant or dependent with respect to whom the certificate applies, and *any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan* and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and *telephone number of the plan administrator or issuer* required to provide the certificate;

(E) The telephone number to call for further information regarding *the* certificate (if different from paragraph (a)(3)(ii)(D) of this section;

(G) *The date creditable coverage ended*, unless the certificate indicates that creditable coverage is continuing as of the date of the certificated; and

(iii) Periods of coverage under the certificate. If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, *the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased.* If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

HMO CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
230	46	46	100%

The examiners reviewed a total of forty-six (46) cancellation files that had been randomly selected from a total population of 230 files. This included a second sample that was requested after the examiner determined the first sample included forty-one (41) files that appeared to be conversions to another plan or group rather than cancellations (some of which were still active), and files with cancellation effective dates outside the time frame of the examination.

The examiners reviewed regenerated copies of certificates of creditable coverage for twenty-four (24) of those forty-six (46) files. The Company indicated it could not provide certificates for the remaining twenty-two (22) files. The regenerated copies have 2007 and 2008 issue dates on them as the Company stated it can reproduce and provide copies only with current dates. The Company also stated it was unable to provide actual copies or copies regenerated with the actual dates the certificates were mailed. In addition, the Company stated the format and information provided on the certificates provided, on all three pages that comprise the certificates, are identical except for the individual information for each member to whom the certificate is addressed.

It appears the Company is not in compliance with Colorado insurance law in that its notice titled "Certificate of Creditable Coverage" consisting of three pages does not include all the information required in federal regulations incorporated in Colorado Insurance Regulation 4-2-18.

Issue 1. The certificates of creditable coverage do not include the telephone number of the plan administrator.

Issue 2. The certificates of creditable coverage do not include an identification number (ID number) that matches the ID number on the Company's record provided to the examiner for each policy,

Issue 3. The certificates of creditable coverage do not include a telephone number to call for more information about the certificate.

Issue 4. The certificates of creditable coverage reviewed do not include the dates the certificates were actually mailed and the Company has provided no objective verification of the timeliness of mailing certificates.

Issue 5. One certificate issued didn't have a termination date but had instead the word "Continued" inserted on the certificate in the "End date" field for a policy terminated in the Company records. While federal regulation does allow that notation for policies that are continuing, the Company had previously stated its additional research showed none of the sample files were active.

Issue 6. One group provided a list of covered employees at termination. Documentation indicates certificates were sent to only eleven (11) of twelve (12) employees covered at termination.

Form	Form Number
Certificate of Creditable Coverage	10340E 09/19/05

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado insurance regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of creditable coverage and any procedures necessary to ensure correct information is included to comply with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means*
>
> (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim,* including any additional medical or other information related to the claim…
>
> *(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
21,487*	50	42	84%

(*9% of all electronic claims)

Using ACL™ software, the examiners identified a total of 21,487 claims that had not been paid, denied or settled within thirty (30) calendar days. A random sample of fifty (50) such claims was selected for review.

It appears the Company is not in compliance with Colorado insurance law in that forty-two (42) of the electronic claims reviewed appeared to represent clean claims, but were not paid, denied, or settled within thirty (30) calendar days.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,293*	50	47	94%

(*10% of all non-electronic claims)

Using ACL™ software, the examiners identified a total of 5,293 claims that had not been paid, denied or settled within forty-five (45) calendar days. A random sample of fifty (50) such claims was selected for review.

It appears the Company is not in compliance with Colorado insurance law in that forty-seven (47) of the paper claims reviewed appear to represent clean claims, but were not paid, denied, or settled within forty-five (45) calendar days.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,979*	50	34	68%

(*2% of all claims)

Using ACL™ software, the examiners identified a total of 4,979 claims paid, denied or settled in excess of ninety (90) days during the period under examination. A random sample of fifty (50) such claims was selected for review.

It appears the Company is not in compliance with Colorado insurance law in that the Company failed to pay, deny or settle thirty-four (34) of the reviewed claims within the required ninety (90) calendar days. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) calendar days of receipt.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay penalties on claims not paid within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5) (b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphasis added.]

CLAIMS PROCESSED OVER 90 CALENDAR DAYS - PAYMENT OF PENALTY

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,979*	50	5	10%

(*2% of all claims)

Using ACL™ software, the examiners identified a total of 4,979 claims paid, denied or settled in excess of ninety (90) calendar days during the examination period. A random sample of fifty (50) claims was selected for review.

Upon review of the fifty (50) claims settled in over ninety (90) calendar days, the examiners determined that a penalty payment was due in five (5) instances. It appears that the Company is not in compliance with Colorado insurance law in that the Company failed to pay a ten (10) percent penalty of the total amount ultimately allowed on the claim to the insured or health care provider on the ninety-first (91st) day on each of the five (5) claims not paid or settled within ninety (90) calendar days.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that the required penalty is paid for any claim not paid, denied, or settled within the time frames required by Colorado insurance law

UTILIZATION REVIEW

(Note: The findings in the Utilization Review Section are deemed to also apply to the market conduct examination of Rocky Mountain Hospital and Medical Service, Inc.)

Issue K1: Failure, in some instances, to provide written notification of first level review adverse determinations within the time frame required by Colorado insurance law.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

G. 1) A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in Paragraph (2) or (3).

(2) With respect to a request for a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, *but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review*.

(3) With respect to a request for a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, *but no later than thirty (30) days after the date of the health carrier's receipt of a request for the first level review*. [Emphases added.]

FIRST LEVEL REVIEW ADVERSE DETERMINATIONS –Written notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,215	50	5	10%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first-level appeal files initiated by "covered persons" or their representatives during the examination period. Each of the fifty (50) first-level appeal files reviewed appeared to be subject to the provisions of Section 10 of Regulation 4-2-17.

It appears that the Company did not meet the requirements of Colorado insurance law in that in five (5) out of the fifty (50) first-level appeal files reviewed, the Company's written notification letter was not provided to the covered person within the thirty (30) day maximum time frame set forth in Colorado Insurance Regulation 4-2-17(10)(G)(2) and (3).

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that it provides written notification letters regarding first level review adverse determinations within the time frames required by Colorado insurance law.

Issue K2: Failure to provide the location of the review panel meeting and thereby discouraging the covered person from requesting a face-to-face meeting.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

A. A carrier may establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person at the review meeting before designated representatives of the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision…

G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:

(2) *Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting*. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodations for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. [Emphases added.]

VOLUNTARY SECOND LEVEL APPEALS – Notification of Review Panel Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
8	4	4	100%

The examiners reviewed the Company's entire population of eight (8) voluntary second-level utilization review appeal files initiated by "covered persons" or their representatives during the examination period. Of the eight (8) files reviewed, two (2) contained decisions that were overturned prior to review by the review panel, and another two (2) were determined to be benefit reviews not subject to the utilization review requirements. The remaining four (4) files were cases where the review panel was scheduled.

It appears that the Company did not meet the requirements of Colorado insurance law in that in all four (4) of the files reviewed, the Company discouraged the covered person and/or their representative(s) from requesting a face-to-face meeting as set forth in Colorado Insurance Regulation 4-2-17(11)(A) and (G)(2) by not fully disclosing the location of the review panel meeting.

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that disclosure of the location of the review panel meeting is provided, and that it does not in any way discourage covered persons and/or their representatives from requesting face-to-face meetings as required by Colorado insurance law.

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